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HEALTH CARE **X**

AMERIGEL[®]
ADVANCED SKIN AND WOUND CARE

 **HELIX**₃
BIOACTIVE COLLAGEN

AMER
KITS & DRESSINGS **X**

EXTREMIT-EASE[®]
COMPRESSION GARMENT

HCPCS CODING GUIDANCE

2025 UPDATE

AMERX[®] SURGICAL DRESSINGS

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AMERX Health Care is proud to introduce the 2025 Update to our HCPCS Coding Guidance for AMERX Surgical Dressings. In this edition, AMERX has indicated updated product information and reimbursement rates for your reference while coding and billing. Be sure to look for the NEW! triangle symbols throughout the book to quickly locate this information.

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HCPCS CODE PRODUCT LISTINGS AND DESCRIPTIONS



The Pricing, Data Analysis, and Coding (PDAC) Contractor has reviewed the products listed below and has approved the listed Healthcare Common Procedure Coding System (HCPCS) codes. The PDAC HCPCS code assignment letters are on file at Amerx Health Care. All HCPCS code assignments and Fee Schedules can be found on the PDAC website: www.dmePDAC.com.

PRODUCT NAME	CATALOG NUMBER	HCPCS CODE*	BILLABLE UNITS	2025 DME MAC FEE SCHEDULE**
AMERIGEL® HYDROGEL WOUND DRESSING, 1oz. TUBE	A2001	A6248	1 unit	\$ 22.70
AMERIGEL® HYDROGEL WOUND DRESSING, 3oz. TUBE	A20103	A6248	3 units	\$ 68.10
AMERIGEL® SALINE WOUND WASH, 4oz. CAN	A50114	A6260	4 units	\$ 0.00
AMERIGEL® SALINE WOUND WASH, 7.1oz. CAN	A50117	A6260	7 units	\$ 0.00
HELIX3-CP® COLLAGEN POWDER, 1 GRAM	H40111	A6010	1 unit	\$ 43.27
HELIX3-CM® COLLAGEN MATRIX DRESSING, 1" X 1"	H40220	A6021	1 unit	\$ 29.38
HELIX3-CM® COLLAGEN MATRIX DRESSING, 2" X 2"	H40221	A6021	1 unit	\$ 29.38
HELIX3-CM® COLLAGEN MATRIX DRESSING, 4" X 4"	H40224	A6021	1 unit	\$ 29.38
HELIX3-CM® COLLAGEN MATRIX DRESSING, 7" X 7"	H40225	A6023	1 unit	\$ 265.90
HELIX3®-CG COLLAGEN GEL, 7 GRAM TUBE	H40401	A6011	7 units	\$ 22.33
AMERX® CALCIUM ALGINATE DRESSING, 2" X 2"	180121	A6196	1 unit	\$ 10.28
AMERX® CALCIUM ALGINATE DRESSING, 4.25" X 4.25"	180125	A6197	1 unit	\$ 22.98
AMERX® FOAM DRESSING, 2" X 2"	190121	A6209	1 unit	\$ 10.44
AMERX® FOAM DRESSING, 4.25" X 4.25"	190125	A6210	1 unit	\$ 27.84
AMERX® BORDERED FOAM DRESSING, 1" X 3.5"	190220	A6413	1 unit	\$ 0.00
AMERX® BORDERED FOAM DRESSING, 4" X 4"	190221	A6212	1 unit	\$ 13.57
AMERX® BORDERED FOAM DRESSING, 3" X 4"	190222	A6212	1 unit	\$ 13.57
AMERX® BORDERED FOAM DRESSING, 6" X 6"	190224	A6212	1 unit	\$ 13.57
AMERX® BORDERED GAUZE DRESSING, 2" X 2"	1G0220	A6219	1 unit	\$ 1.33
AMERX® BORDERED GAUZE DRESSING, 4" X 4"	1G0221	A6219	1 unit	\$ 1.33
AMERX® BORDERED GAUZE DRESSING, 6" X 6"	1G0226	A6220	1 unit	\$ 3.62
AMERX® RETENTION TAPE, 2" x 11 Yards	1T0154	A4452	44 units	\$ 11.13

For Venous Insufficiency

EXTREMIT-EASE® COMPRESSION GARMENT (XS-XXL)	E10140-E20245	A6545	1 unit	\$ 119.03
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NEW - For Lymphedema

EXTREMIT-EASE® COMPRESSION GARMENT (XS-XXL)	E10140-E20245	A6583	3 units	\$ 155.92
EXTREMIT-EASE® GARMENT LINER (XS-XXL)	E90001-E90015	A6594	3 units	\$ 34.13

* Product name does not necessarily determine PDAC-assigned code. <https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/list-cpt/hcpcs-codes>

** Fee Schedule based on Non-Rural Ceiling. <https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule/dme24>

COVERAGE AND REIMBURSEMENT RULES

The following information summarizes the DMEMACs "Surgical Dressings" LCD (L33831), "Surgical Dressings" Policy Article (A54563), and Local Coverage Article, "Standard Documentation Requirements for All Claims Submitted to DME MACs" (A55426). For additional information, the LCD is available at: <http://bit.ly/2020L33831>. Medicare guidelines apply to Medicare beneficiaries. Many non-Medicare payers follow Medicare guidelines for coverage of surgical dressings, but not all do. For non-Medicare beneficiaries, providers should check with the payer for coverage guidelines.

For any item to be covered by Medicare, it must (1) be eligible for a defined Medicare benefit category, (2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) meet all other applicable Medicare statutory and regulatory requirements. <https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coverage/medicare-coverage-items-and-services>

QUALIFYING WOUND

Surgical dressings are covered when the following conditions are met:

1. A qualifying wound is present.
2. The requirements of that particular dressing are satisfied by the description of the ulcer.
3. The dressing is medically necessary.

A qualifying wound is defined as either of the following:

- A wound caused by, or treated by, a surgical procedure; or,
- A wound that requires debridement, regardless of the debridement technique.

The surgical procedure or debridement must be performed by a physician or other healthcare professional to the extent permissible under State law. Debridement of a wound may be any type of debridement (examples given are not all-inclusive): (a) Surgical (e.g., sharp instrument or laser); (b) Mechanical (e.g., irrigation or wet-to-dry dressings); (c) Chemical (e.g., topical application of enzymes); or (d) Autolytic (e.g., application of occlusive dressings to an open wound). Dressings used for mechanical debridement, to cover chemical debriding agents, or to cover wounds to allow for autolytic debridement are covered although the debridement agents themselves are non-covered.

Ulcer debridement may be coded with CPT® 97597, CPT 97598, and CPT 11042 - CPT 11047¹. The CPT code you use should be based upon not the depth of the ulcer but rather the deepest depth of tissue which is debrided (CPT Professional[®]). Be sure to read any applicable coverage determination for ulcer debridement for each patient to ensure complete documentation. These determinations may differ based on third party payer and geographic location. Debridement CPT codes quantify the amount of tissue debrided. If multiple ulcers are debrided to the same depth, the CPT code is based upon the total amount of tissue removed from all ulcers debrided at that depth.

Examples (not all-inclusive) of clinical situations in which dressings are non-covered by the DMEMACs:

- Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure; or,
- A Stage I pressure ulcer; or
- A first degree burn; or
- Wounds caused by trauma which do not require surgical closure or debridement - e.g., skin tear or abrasion; or,
- A venipuncture or arterial puncture site (e.g., blood sample) other than the site of an indwelling catheter or needle.

GENERAL

Medicare provides reimbursement for surgical dressings under the Surgical Dressings Benefit. This benefit only provides coverage for primary and secondary surgical dressings used on the skin for specified wound types.

- **Primary Dressings** – Defined as therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin; and,
- **Secondary Dressings** – Defined as materials that serve a therapeutic or protective function and that are needed to secure a primary dressing.

When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is not required. Medical necessity for use of additional tape must be well documented.

Use of more than one type of wound filler or more than one type of wound cover in a single wound is not reasonable and necessary. The exception is a primary dressing composed of: (1) an alginate or other fiber gelling dressing; or, (2) a saline, water, or hydrogel impregnated gauze dressing. Either of these might need an additional wound cover.

It is not appropriate to dispense combinations of a hydrating dressing and an absorptive dressing (e.g., hydrogel and alginate) for the same wound at the same time.

The frequency of recommended dressing changes depends on the wound characteristics and the type and use of the surgical dressing. When combinations of primary dressings, secondary dressings, and/or wound filler are used, the change frequencies of the individual products should be similar. For purposes of the policy, the product in contact with the wound determines the change frequency. It is not reasonable and necessary to use a combination of products with differing change intervals. For example, it is not reasonable and necessary to use a secondary dressing with a weekly change frequency over a primary dressing with a daily change interval. Such claims will be denied as not reasonable and necessary.

It is not reasonable and necessary to use a secondary dressing with primary dressings that contain an impervious backing layer with or without an adhesive border.

Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about 2 inches greater than the dimensions of the wound. For example, a 2 in. x 2 in. wound usually requires a 4 in. x 4 in. pad size.

The quantity, type, and size of dressings dispensed at any one time must take into account the status of the wound(s), the likelihood of change, and the recent use of dressings.

Dressing needs may change frequently (e.g., weekly) in the early phases of wound treatment and/or with heavily draining wounds. Suppliers are required to monitor the quantity of dressings that the beneficiary is actually using and to adjust their provision of dressings accordingly.

Surgical dressings must be tailored to the specific needs of an individual beneficiary. When surgical dressings are provided in kits, only those components of the kit that meet the definition of a surgical dressing, that are ordered by the treating physician, and that are reasonable and necessary are covered.

If a treating practitioner applies surgical dressings as part of a professional service that is billed to Medicare, the surgical dressings are considered incident to the professional services of the health care practitioner and are not separately payable. Claims for these dressings must not be submitted. Claims for the professional service, which includes the dressings, must be submitted to the local carrier or intermediary. If dressing changes are sent home with the beneficiary, claims for these dressings may be submitted. In this situation, use the place of service corresponding to the beneficiary's residence; Place of Service Office (POS=11) must not be used.

Clinical information, which demonstrates that the reasonable and necessary requirements regarding the type and quantity of surgical dressings provided, must be present in the beneficiary's medical records. This information must be updated by the treating physician (or their designee) on a monthly basis. This evaluation of the beneficiary's wound(s) is required unless there is documentation in the medical record which justifies why an evaluation could not be done within this time frame and what other monitoring methods were used to evaluate the beneficiary's need for ongoing use of dressings.

Evaluation is expected on a weekly basis for beneficiaries in a nursing facility or for beneficiaries with heavily draining or infected wounds. The evaluation may be performed by a nurse, physician or other health care professional involved in the regular care of the beneficiary.

This evaluation must include: (a) The type of each wound (e.g., surgical wound, pressure ulcer, burn, etc.); (b) Wound(s) location; (c) Wound size (length x width) and depth; (d) Amount of drainage; and (e) Any other relevant wound status information.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary. The POD must include the following: beneficiary's name, delivery address (your practice address if dispensed from your office), sufficiently detailed description identifying item(s) being delivered (e.g. brand names, serial/lot number, narrative description), quantity delivered, date delivered, beneficiary (or designee) signature. Date of service is the delivery date.

REFILL REQUIREMENTS

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the treating practitioner that any changed or atypical utilization is warranted. Regardless of utilization, no more than a month's supply of dressings may be provided at one time, unless there is documentation to support the necessity of greater quantities in the home setting in an individual case.

PLACE OF SERVICE

If medically necessary surgical dressings are sent home with the patient, claims for these dressings may be submitted to the appropriate third party payer. In this situation, **use the place of service corresponding to the patient's residence (POS=12)**; Place of Service Office (POS=11) must NOT be used.

MODIFIER USAGE

When surgical dressings are billed to Medicare, the appropriate modifier (A1 – A9, AW, EY, or GY) must be added to the code when applicable. If A9 is used, information must be submitted with the claim indicating the number of wounds. If GY is used, a brief description of the reason for non-coverage (e.g., "A6216GY - used for wound cleansing") must be entered in the narrative field of the electronic claim.

Modifiers A1 – A9 have been established to indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also to indicate the number of wounds on which that dressing is being used. The number that follows "A" in the modifier must correspond to the number of wounds on which the dressing is being used, not the total number of wounds treated. For example, if the patient has four (4) wounds but a particular dressing is only used on two (2) of them, the A2 modifier must be used with that HCPCS code. Do not use any of the A1 - A9 modifiers with A6545.

 See sample Form 1500—Multiple Wounds (Primary Dressings Only) on page 15 for an example.

Modifiers AW, RT, and LT are used when an item is furnished in conjunction with a surgical dressing such as a gradient compression wrap. When billing code A6545, the code must include an AW modifier and the corresponding RT or LT modifier to indicate Right Side (RT) or Left Side (LT). The RT and/or LT modifiers must be used with code A6545 for gradient compression stockings and wraps. **Claims billed without modifiers RT and/or LT will likely be rejected for incorrect coding.**

 See sample Form 1500—Single Wound (Primary Dressing + Compression) on page 14 for an example.

When dispensing two of the same items to be used bilaterally, list each item on two separate claim lines with a "RT" modifier on one and a "LT" modifier on the other, along with the corresponding number of units dispensed of each.

Modifier KX should **NOT** be used when billing Medicare for Surgical Dressings. The current LCD states “When surgical dressings are billed (to Medicare), the appropriate modifier (A1 – A9, AW, EY, or GY) must be added to the code when applicable” and makes no mention of the KX modifier. However, some commercial payers do require the KX modifier.

Hospice Patients: Surgical dressings, including EXTREMIT-EASE, may be covered for hospice patients if the service is unrelated to the patient’s terminal condition. If the documentation supports the claim that the service is unrelated to the patient’s terminal condition, the GW Modifier should be appended.

MODIFIERS

A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	If A9 is billed, the claim must include the number of wounds
AW	Item furnished in conjunction with a surgical dressing
EY	No physician or other licensed health care provider order for this item or service
GY	Item or service statutorily excluded, does not meet the definition of any Medicare benefit, or for non-medicare insurers, is not the contract benefit must be entered in the narrative field of the electronic claim.
GW	Service not related to the hospice patient's terminal condition.
RT	Right Side
LT	Left Side

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

SURGICAL DRESSINGS

When the prescribing practitioner is also the supplier, and is permitted to furnish specific items of DMEPOS, a separate order is not required, provided the medical record contains all of the required order elements. Please note that nothing in this policy affects the application of the Physician Self-Referral Law.

MACs will look to the entirety of the medical record, in those limited instances in which the prescribing practitioner is also the supplier permitted to furnish specific DMEPOS, to fulfill the elements of the written order. MACs will not expect the practitioner to write a separate order to himself/herself.

The medical records or **SWO (Standard Written Order)** must specify (a) the Beneficiary's name or Medicare Beneficiary Identifier (MBI), (b) the order date, (c) a description of the item, (d) the quantity to be dispensed (if applicable), (e) the treating practitioner's name or NPI number, and (f) the treating practitioner's signature.

A new order is needed if a new dressing is added or if the quantity of an existing dressing to be used is increased. A new order is not routinely needed if the quantity of dressings used is decreased. However, a new order is required at least every 3 months for each dressing being used even if the quantity used has remained the same or decreased.

When using the AMERX Patient Direct Program, the order forms provided by AMERX, when completed, fulfill the Standard Written Order (SWO) requirement. A copy of this order form must be scanned into the patients records following completion, including signatures by both the provider and the patient.

"Partial-thickness" wounds have a loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. A partial-thickness wound does NOT breach the dermis where subcutaneous tissue is not visible and may also present as an intact or open/ruptured serum-filled blister.

"Full-thickness" wounds breach the dermis. Subcutaneous tissue may be visible. Slough may be present but does not obscure the depth of tissue loss. Full-thickness wounds may also include undermining and tunneling.

TAPE (A4450, A4452): Tape is covered when needed to hold on a wound cover, elastic roll gauze or non-elastic roll gauze. Additional tape is not required when a wound cover with an adhesive border is used. Tape change is determined by the frequency of change of the wound cover. Quantities of tape submitted must reasonably reflect the size of the wound cover being secured. Utilization per dressing change for wound covers measuring: 16 square inches or less is up to 2 units; 16 to 48 square inches, up to 3 units; Greater than 48 square inches, up to 4 units. Claims for tape (A4450 and A4452) which are billed without an AW modifier or another modifier indicating coverage under a different policy will be rejected as missing information. **Maximum Allowable: Varies depending on wound type, location, and primary dressing requirements.**

A4452: TAPE, WATERPROOF, PER 18 SQUARE INCHES

GAUZE, NON-IMPREGNATED (A6216-A6221, A6402-A6404, A6407): Non-impregnated gauze dressing change is up to 3 times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than 2 gauze pads on top of each other in any one area. **Maximum Allowable: Varies depending on wound type, location, and primary dressing requirements.**

A6219: GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING

A6220: GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE

A6402: GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

ALGINATE OR OTHER FIBER GELLING DRESSING (A6196-A6199): Alginate or other fiber gelling dressing covers are covered for moderately to highly exudative full thickness wounds (e.g., stage III or IV ulcers); and alginate or other fiber gelling dressing fillers for moderately to highly exudative full thickness wound cavities (e.g., stage III or IV ulcers). They are not reasonable and necessary on dry wounds or wounds covered with eschar. Dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to 2 units of wound filler (1 unit = 6 inches of alginate or other fiber gelling dressing rope) is used at each dressing change.

Maximum Allowable: 30 units per wound per month.

A6196: ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING

A6197: ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING

Calcium alginate dressings can serve as either a primary or secondary dressing.

COLLAGEN DRESSINGS, WOUND FILLER (A6010, A6011, A6021-A6024): A collagen-based dressing or wound filler is covered for full thickness wounds (e.g., stage III or IV ulcers), wounds with light to moderate exudate, or wounds that have stalled or have not progressed toward a healing goal. They can stay in place up to 7 days, depending on the specific product. Collagen based dressings are not covered for wounds with heavy exudate, third-degree burns, or when an active vasculitis is present. **Maximum Allowable: 30 Pads or grams per wound per month.**

A6010: COLLAGEN BASED WOUND FILLER, DRY FORM, STERILE, PER GRAM OF COLLAGEN

A6011: COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM OF COLLAGEN

A6021: COLLAGEN DRESSING, STERILE, SIZE 16 SQ. IN. OR LESS, EACH

A6022: COLLAGEN DRESSING, STERILE, SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH

A6023: COLLAGEN DRESSING, STERILE, SIZE MORE THAN 48 SQ. IN., EACH

FOAM DRESSING (A6209-A6215): Foam dressings are covered when used on full thickness wounds (e.g., stage III or IV ulcers) with moderate to heavy exudate. Dressing change for a foam wound cover used as a primary dressing is up to 3 times per week. When a foam wound cover is used as a secondary dressing for wounds with very heavy exudate, dressing change is up to 3 times per week.

Maximum Allowable: 12 units per wound per month.

A6209: FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

A6210: FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING

A6212: FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING

HYDROGEL DRESSING (A6248): Hydrogel dressings are covered when used on full thickness wounds (e.g., stage III or IV ulcers) with minimal or no exudate. Hydrogel dressings are not reasonable and necessary for stage II ulcers. Dressing change for hydrogel wound fillers is up to once per day. The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not reasonable and necessary. Maximum utilization of code A6248 is three (3) units (fluid ounces) per wound in 30 days. Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not reasonable and necessary. **Maximum Allowable: 3 oz. per wound per month**

A6248: HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE

NEW LYMPHEDEMA ACT UPDATES 2025

GRADIENT COMPRESSION WRAP FOR VENOUS INSUFFICIENCY (A6545): A gradient compression wrap is only covered when it is used as a primary or secondary dressing over wounds that meet the statutory requirements for a qualifying wound (surgically created or modified, or debrided). A non-elastic gradient compression wrap described by code A6545 is only covered when it is used in the treatment of an open venous stasis ulcer that meets the qualifying wound requirements. Claims for gradient compression wraps used without a qualifying wound or when used for other non-qualifying conditions will be denied as statutorily non-covered, no benefit. Code A6545 is non-covered for the following conditions: (a) Venous insufficiency without stasis ulcers; (b) Prevention of stasis ulcers; (c) Prevention of the reoccurrence of stasis ulcers that have healed; or (d) Treatment of lymphedema in the absence of ulcers. Claim lines for A6545 without an AW modifier (A1-A9 modifiers are not required for these codes) will be rejected for missing information. Utilization of a gradient compression wrap (A6545) is limited to one per 6 months per leg. Quantities exceeding this amount will be denied as not reasonable and necessary. The only products that may be billed using code A6545 (non-elastic compression wrap) are those for which a written CVR has been made by the PDAC contractor and subsequently published on the PCL. Maximum Allowable: 1 unit per leg every 6 months.

A6545: GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MMHG, USED AS A SURGICAL DRESSING.

GRADIENT COMPRESSION WRAP FOR LYMPHODEMA (A6583, A6594): Gradient compression garments, related supplies and accessories are covered only for the treatment of lymphedema (see ICD-10-CM Codes that Support Medical Necessity). Claims for gradient compression garments, related supplies and accessories for non-lymphedema diagnoses will be denied as not reasonable and necessary. A quantity of three (3) daytime garments or wraps per body area are allowed once every six (6) months. Replacement of the garments can only be made in accordance with the frequency limitations of once every six (6) months for daytime garments.

A6583 - GRADIENT COMPRESSION WRAP WITH ADJUSTABLE STRAPS, BELOW KNEE, 30-50 MMHG, EACH.

A6594 - GRADIENT COMPRESSION BANDAGING SUPPLY, BANDAGE LINER, LOWER EXTREMITY, ANY SIZE OR LENGTH, EACH.

PRACTITIONER COMPLIANCE PEARLS

GENERAL RECOMMENDATIONS:

1. Surgical Dressings are generally **NOT** covered for Medicare beneficiaries if the patient is under Home Health Care PPS, receiving hospice care, or under a Medicare Part A stay.
2. Keep detailed and complete documentation on each wound and any DME products you are dispensing.
3. Have your patient sign a POD (Proof of Delivery) confirming they have received the product(s) the day it was dispensed. (See examples on page 16-18)
4. Use a comprehensive wound tracking form to compile statistics for each wound or create a medical record with the essential elements. If a form is used, it should be kept in the patient's file.
5. All wounds should be measured in Length x Width x Depth. Photographs are recommended.
6. Dressings placed on the wound(s) in the practice or treatment facility on the day of service are considered part of the service fee and are not individually billable.
7. If all of the documentation requirements of a debridement and SWO are present, when surgical dressings are dispensed, you must also document the medical necessity of the dressing being dispensed, why this dressing type was selected, and if it is to be used as a primary dressing or a secondary dressing.

SPECIFICS FOR COMPLETING HCFA 1500 FORM FOR HOME USE:

See example forms (pages 12-15)

1. Box "17" must include the DK (ordering physician) or DN (referring physician) qualifier to the left of the vertical dotted line followed by the physician's name to the right of the dotted line.
2. Box "17b" must include the NPI# of the physician, primary contract holder, or group.
3. Box "21" requires an ICD-10 CM diagnosis code. Venous Stasis ulcer codes begin with I83-, and non-pressure ulcer codes begin with L97-. When coding a full-thickness wound, the L97- sixth character (digit) will need to be 2 or greater. **DO NOT use "unspecified" codes and be as anatomically specific as possible.**
4. Box "24A" is the date of service the patient receives the Surgical Dressing for home use.
5. Box "24B" Place of Service for **Home Use = POS 12.**
6. Box "24D" requires the HCPCS Code assigned by PDAC for the Surgical Dressing dispensed (e.g. A6248 – Hydrogel Wound Dressing).
7. Box "24D" "MODIFIER" — This is where you record the number of wounds treated; **A1** for one wound, **A2** for two wounds, etc.; and/or the place the **AW** with **RT** or **LT** modifiers when using a gradient compression wrap in conjunction with a surgical dressing.
8. Box "24F" — Enter the total amount of "\$ CHARGES" for supplies dispensed.
9. Box "24G" — Document the **number of units** (not days) of DME products dispensed to the patient.
10. Box "31" — Must include the date and physician signature (can use "Signature On File").
11. Box "32" — Location where the DME Item was furnished. The location/organization NPI number should be used in box 33a.
12. Box "33" — Billing address and contact information

EXAMPLE FORM 1500: MULTIPLE WOUNDS (PRIMARY DRESSING ONLY)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000000000A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane A.										3. PATIENT'S BIRTH DATE MM DD YY 12 17 40									
5. PATIENT'S ADDRESS (No., Street) 123 Any Street										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY Anytown					STATE FL					7. INSURED'S ADDRESS (No., Street) 123 Any Street					8. RESERVED FOR NUCC USE				
ZIP CODE 45678					TELEPHONE (Include Area Code) (123) 456-7890					CITY Anytown					STATE FL				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY 12 17 40					b. OTHER CLAIM ID (Designated by NUCC)				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. INSURED'S SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					c. INSURANCE PLAN NAME OR PROGRAM NAME				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____ DATE _____										SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JOHN DOE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24b)) A. L97.412 B. L97.322										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										24. B. PLACE OF SERVICE EMG									
24. C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										24. D. DIAGNOSIS POINTER									
24. E. \$ CHARGES										24. F. DAYS OR UNITS									
24. G. H. I. J.										24. K.									
25. FEDERAL TAX I.D. NUMBER 00-0000000										26. PATIENT'S ACCOUNT NO. AAA00000									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$									
29. AMOUNT PAID \$										30. Rsvd. for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>John Doe</i> 09/01/18										32. SERVICE FACILITY LOCATION INFORMATION FOOT & ANKLE CLINIC 1000 TOE WAY CLEARWATER, FL 33756									
33. BILLING PROVIDER INFO & PH # (345) 678-9012 JOHN DOE 1000 TOE WAY CLEARWATER, FL 33756										a. OFFICE NPI# b. BILLING NPI#									

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PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

EXAMPLE FORM 1500: SINGLE WOUND (PRIMARY DRESSING + COMPRESSION)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000000000A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane A.										3. PATIENT'S BIRTH DATE MM DD YY 12 17 40									
5. PATIENT'S ADDRESS (No., Street) 123 Any Street										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY Anytown					STATE FL					7. INSURED'S ADDRESS (No., Street) 123 Any Street					8. RESERVED FOR NUCC USE				
ZIP CODE 45678					TELEPHONE (Include Area Code) (123) 456-7890					CITY Anytown					STATE FL				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY 12 17 40					b. RESERVED FOR NUCC USE				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)					c. RESERVED FOR NUCC USE				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY									
15. OTHER DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JOHN DOE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY									
17a. NPI PHYSICIAN NPI#										20. OUTSIDE LAB? \$ CHARGES									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										22. RESUBMISSION CODE ORIGINAL REF. NO.									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24b) ICD Ind. 0										23. PRIOR AUTHORIZATION NUMBER									
A. I83.012 B. L97.212										24. DATE(S) OF SERVICE From To MM DD YY MM DD YY									
C. PLACE OF SERVICE EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER									
E. DIAGNOSIS POINTER										F. \$ CHARGES									
G. DAYS OR UNITS										H. ICD-9-CM Family Hist									
I. ID. QUAL										J. RENDERING PROVIDER ID. #									
1 09 01 18 12 A6010 A1 A,B 1500.00 30 NPI PHYSICIAN NPI#										25. FEDERAL TAX I.D. NUMBER SSN EIN 00-0000000									
2 09 01 18 12 A6545 AW RT A,B 150.00 1 NPI PHYSICIAN NPI#										26. PATIENT'S ACCOUNT NO. AAA00000									
3										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
4										28. TOTAL CHARGE \$									
5										29. AMOUNT PAID \$									
6										30. Rsvd. for NUCC Use									
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a. OFFICE NPI#										b. BILLING NPI#									
33. BILLING PROVIDER INFO & PH # (345) 678-9012 JOHN DOE 1000 TOE WAY CLEARWATER, FL 33756										a. BILLING NPI#									

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APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

EXAMPLE FORM 1500: LYMPHEDEMA



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA <input type="checkbox"/> PICA																																																																																																																																																																					
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BENEFIT <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000000000A																																																																																																																																																																
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PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PROOF OF DELIVERY (RECEIPT OF INDIVIDUAL DME SUPPLIES)

DELIVERY ADDRESS*: _____

*Where the product was handed/delivered to the patient (i.e. Practice Address)

PATIENT NAME: _____

DOB: _____

DATE DELIVERED: _____

QTY	ITEM SIZE	PRESCRIBED ITEM AND DESCRIPTION	HCPCS CODE
		AMERIGEL® - Hydrogel (1oz., 3oz.) - Hydrogel, Wound Filler, Gel, Per Fluid Ounce	A6248
		AMERX® - Calcium Alginate Dressing (2x2) - Alginate or Other Fiber Gelling Dressing, Wound Cover, Sterile, Pad Size 16 Sq. In. or Less, Each Dressing	A6196
		AMERX® - Calcium Alginate Dressing (4.25x4.25) - Alginate or Other Fiber Gelling Dressing, Wound Cover, Sterile, Pad Size 16 Sq. In. or Less, Each Dressing	A6197
		AMERX® - Foam Dressing (2x2) - Foam Dressing, Wound Cover, Sterile, Pad Size 16 Sq. In. or Less, W/Out Adhesive Border, Each Dressing	A6209
		AMERX® - Foam Dressing (4.25x4.25) - Foam Dressing, Wound Cover, Sterile, Pad Size 16 Sq. In. or Less, W/ Out Adhesive Border, Each Dressing	A6210
		AMERX® - Bordered Foam Dressing (1x3.5) - Adhesive bandage, first-aid type, any size, each	A6413
		AMERX® - Bordered Foam Dressing (3x4, 4x4, 6x6) - Foam Dressing, Wound Cover, Sterile, Pad Size 16 Sq. In. or Less, W/ Any Size Adhesive Border, Each Dressing	A6212
		AMERX® - Bordered Gauze Dressing (2x2, 4x4) - Gauze, Non-impregnated, Sterile, Pad Size 16 Sq. In. or Less, W/ Any Size Adhesive Border, Each Dressing	A6219
		AMERX® - Bordered Gauze Dressing (6x6) - Gauze, Non-impregnated, Sterile, Pad Size More Than 16 Sq. In. But Less Than or Equal to 48 Sq. In., W/ Any Size Adhesive Border, Each Dressing	A6220
		HELIX3-CP® Collagen Powder (1g.) - Collagen Based Wound Filler, Dry Form, Sterile, Per Gram of Collagen	A6010
		HELIX3-CM® Collagen Matrix (1x1, 2x2, 4x4) - Collagen Dressing, Sterile, Size 16 Sq. In. or Less, Each	A6021
		HELIX3-CM® Collagen Matrix (7x7) - Collagen Dressing, Sterile, Size More Than 48 sq. in., each	A6023
		HELIX3®-CG Collagen Gel (7g.) - Collagen Based Wound Filler, Gel/Paste, Per Gram of Collagen	A6011

BRAND NAME: _____

SERIAL/LOT NUMBER: _____

SUPPLY WARRANTY INFORMATION: By signing below, I am certifying that I have received the above designated item and that the item is satisfactory, fit for use and not substandard in any way. Due to the medical nature of these devices, they cannot be returned. The products and/or services provided to you are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://www.ecfr.gov>. Upon request we will furnish you a written copy of the standards.

- I have received a copy of the Privacy Policy on this visit or on a previous visit as noted in my medical record.
- I received instructions on proper use of the prescribed devices.
- I received my DMEPOS items.

By signing below, I acknowledge and understand all of the above.

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS: _____

PRINTED NAME: _____

DATE: _____

PROOF OF DELIVERY (RECEIPT OF DME KIT SUPPLIES)

DELIVERY ADDRESS: _____

Where the product was handed/delivered to the patient (i.e. Practice Address)

PATIENT NAME: _____ **DOB:** _____ **DATE DELIVERED:** _____

QTY	SIZE	PRESCRIBED ITEM AND DESCRIPTION	HCPCS CODE
	30-Day Kit	AMERX® Calcium Alginate Wound Care Kit w/Bordered Gauze - Each Kit Contains: 30 Calcium Alginate Dressings(2x2), 30 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6196, A6219, A6216
	30-Day Kit	AMERX® Calcium Alginate Wound Care Kit w/Rolled Gauze - Each Kit Contains: 30 Calcium Alginate Dressings(2x2), 8 Rolled Gauze Dressings(3in.), 30 Sterile Gauze Pads(4x4), 2 Paper Tape(1in.) and Saline Wound Wash	A6196, A6446, A6402, A4450
	30-Day Kit	AMERX® Collagen Matrix Wound Care Kit w/Bordered Gauze - Each Kit Contains: 30 Collagen Dressings(2x2), 30 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6021, A6219, A6216
	30-Day Kit	AMERX® Collagen Matrix Wound Care Kit w/Rolled Gauze - Each Kit Contains: 30 Collagen Dressings(2x2), 8 Rolled Gauze Dressings(3in.), 30 Sterile Gauze Pads(4x4), 2 Paper Tape(1in.) and Saline Wound Wash	A6021, A6446, A6402, A4450
	30-Day Kit	AMERX® Collagen Powder Wound Care Kit w/Bordered Gauze - Each Kit Contains: 30 Collagen Powder(1g.), 30 Bordered Gauze Dressings(2x2), 30 Gauze(2x2) and Saline Wound Wash	A6010, A6219, A6216
	30-Day Kit	AMERX® Collagen Powder Wound Care Kit w/Bordered Gauze - Each Kit Contains: 30 Collagen Powder(1g.), 30 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6010, A6219, A6216
	30-Day Kit	AMERX® Collagen Powder Wound Care Kit w/Rolled Gauze - Each Kit Contains: 30 Collagen Powder(1g.), 8 Rolled Gauze Dressings(3in.), 30 Sterile Gauze Pads(4x4), 2 Paper Tape(1in.) and Saline Wound Wash	A6010, A6446, A6402, A4450
	30-Day Kit	AMERX® Foam Wound Care Kit w/Bordered Gauze - Each Kit Contains: 12 Foam Dressings(2x2), 15 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6209, A6219, A6216
	30-Day Kit	AMERX® Foam Wound Care Kit w/Rolled Gauze - Each Kit Contains: 12 Foam Dressings(2x2), 8 Rolled Gauze Dressings(3in.), 30 Sterile Gauze Pads(4x4), 2 Paper Tape(1in.) and Saline Wound Wash	A6209, A6446, A6402, A4450
	30-Day Kit	AMERX® Hydrogel Wound Care Kit w/Bordered Gauze - Each Kit Contains: Hydrogel Dressing(3oz.), 30 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6248, A6219, A6216
	30-Day Kit	AMERX® Hydrogel Wound Care Kit w/Rolled Gauze - Each Kit Contains: Hydrogel Dressing(3oz.), 8 Rolled Gauze Dressings(3in.), 30 Sterile Gauze Pads(4x4), 2 Paper Tape(1in.) and Saline Wound Wash	A6248, A6446, A6402, A4450
	15-Day Kit	AMERX® Calcium Alginate Wound Care Kit w/Bordered Gauze - Each Kit Contains: 15 Calcium Alginate Dressings(2x2), 15 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6196, A6219, A6216
	15-Day Kit	AMERX® Calcium Alginate Wound Care Kit w/Rolled Gauze - Each Kit Contains: 15 Calcium Alginate Dressings(2x2), 4 Rolled Gauze Dressings(3in.), 15 Sterile Gauze Pads(4x4), 1 Paper Tape(1in.) and Saline Wound Wash	A6196, A6446, A6402, A4450
	15-Day Kit	AMERX® Collagen Matrix Wound Care Kit w/Bordered Gauze - Each Kit Contains: 15 Collagen Dressings(2x2), 15 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6021, A6219, A6216
	15-Day Kit	AMERX® Collagen Matrix Wound Care Kit w/Rolled Gauze - Each Kit Contains: 15 Collagen Dressings(2x2), 4 Rolled Gauze Dressings(3in.), 15 Sterile Gauze Pads(4x4), 1 Paper Tape(1in.) and Saline Wound Wash	A6021, A6446, A6402, A4450
	15-Day Kit	AMERX® Collagen Powder Wound Care Kit w/Bordered Gauze - Each Kit Contains: 15 Collagen Powder(1g.), 15 Bordered Gauze Dressings(2x2), 30 Gauze(2x2) and Saline Wound Wash	A6010, A6219, A6216
	15-Day Kit	AMERX® Collagen Powder Wound Care Kit w/Bordered Gauze - Each Kit Contains: 15 Collagen Powder(1g.), 15 Bordered Gauze Dressings(4x4), 30 Gauze(2x2) and Saline Wound Wash	A6010, A6219, A6216
	15-Day Kit	AMERX® Collagen Powder Wound Care Kit w/Rolled Gauze - Each Kit Contains: 15 Collagen Powder(1g.), 4 Rolled Gauze Dressings(3in.), 15 Sterile Gauze Pads(4x4), 1 Paper Tape(1in.) and Saline Wound Wash	A6010, A6446, A6402, A4450
	5-Day Kit	AMERX® Collagen Powder Wound Care Kit w/Bordered Gauze - Each Kit Contains: 5 Collagen Powder(1g.), 15 Bordered Gauze Dressings(2x2), 30 Gauze(2x2) and Saline Wound Wash	A6010, A6219, A6216

BRAND NAME: _____ **SERIAL/LOT NUMBER:** _____

SUPPLY WARRANTY INFORMATION: By signing below, I am certifying that I have received the above designated item and that the item is satisfactory, fit for use and not sub-standard in any way. Due to the medical nature of these devices, they cannot be returned. The products and/or services provided to you are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://www.ecfr.gov>. Upon request we will furnish you a written copy of the standards.

- I have received a copy of the Privacy Policy on this visit or on a previous visit as noted in my medical record.
- I received instructions on proper use of the prescribed devices.
- I received my DMEPOS items.

By signing below, I acknowledge and understand all of the above.

PATIENT/GUARDIAN SIGNATURE: _____ **WITNESS:** _____

PRINTED NAME: _____ **DATE:** _____

PROOF OF DELIVERY (COMPRESSION GARMENT)

PRACTICE NAME: _____

DELIVERY ADDRESS*: _____

*Where the product was handed/delivered to the patient (i.e. Practice Address)

PATIENT NAME: _____ DOB: _____ DATE DELIVERED: _____

QUANTITY	PRESCRIBED ITEM AND DESCRIPTION	HCPCS CODE
	EXTREMIT-EASE® Compression Garment (Regular - XS-XXL) Gradient compression wrap, non-elastic, below knee, 30-50mmHG, used as a surgical dressing	A6545
	EXTREMIT-EASE® Compression Garment (Tall - XS-XXL) Gradient compression wrap, non-elastic, below knee, 30-50mmHG, used as a surgical dressing	A6545
	EXTREMIT-EASE® Compression Garment (Regular - XS-XXL) Gradient compression wrap with adjustable straps, below knee, 30-50mmHG, Sizes, Each	A6583
	EXTREMIT-EASE® Compression Garment (Tall - XS-XXL) Gradient compression wrap with adjustable straps, below knee, 30-50mmHG, Sizes, Each	A6583

BRAND NAME: _____ SERIAL/LOT NUMBER: _____

SIZE: _____ XSMALL _____ SMALL _____ MEDIUM _____ LARGE _____ XLARGE _____ 2XLARGE

_____ Right _____ Left _____ Bilateral # of Wounds (if applicable) _____

SUPPLY WARRANTY INFORMATION: By signing below, I am certifying that I have received the above designated item and that the item is satisfactory, fit for use and not substandard in any way. All devices eventually wear out through normal wear and tear. The products you have received have a 6 MONTH manufacturer's warranty against defects in materials and workmanship, assuming normal wear and tear. We will repair or replace free of charge devices that are under warranty. Due to the medical nature of these devices, they cannot be returned, unless defective and under warranty. The products and/or services provided to you are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://www.ecfr.gov>. Upon request we will furnish you a written copy of the standards.

- I have received a copy of the Privacy Policy on this visit or on a previous visit as noted in my medical record.
- I received instructions on proper use of the prescribed devices.
- I received my DMEPOS items.

By signing below, I acknowledge and understand all of the above.

PATIENT/GUARDIAN SIGNATURE: _____ WITNESS: _____

PRINTED NAME: _____ DATE: _____

STANDARD WRITTEN ORDER (WOUND DRESSING)

ORDER DATE: _____ BENEFICIARY (PATIENT) NAME/MBI: _____

PRACTICE NAME: _____

TREATING PRACTITIONER'S NAME/NPI: _____

PRIMARY DRESSINGS TO BE DISPENSED

Indicate dressings for each wound with "✓". One dressing per change unless otherwise noted. Bordered dressings listed at pad size.

PRODUCT	DRAINAGE	HCPCS	UNIT/PAD SIZE	WOUND #1 QTY. ORDERED	WOUND #2 QTY. ORDERED	WOUND #3 QTY. ORDERED
AMERIGEL® Hydrogel	Min	A6248	<input type="checkbox"/> 1 oz. <input type="checkbox"/> 3 oz.	<input type="checkbox"/> 1 oz. <input type="checkbox"/> 3 oz. (max)	<input type="checkbox"/> 1 oz. <input type="checkbox"/> 3 oz. (max)	<input type="checkbox"/> 1 oz. <input type="checkbox"/> 3 oz. (max)
HELIX3-CP® Collagen Powder	Min-Mod	A6010	<input type="checkbox"/> 1 gram	<input type="checkbox"/> 10g <input type="checkbox"/> 15g <input type="checkbox"/> 30g (max)	<input type="checkbox"/> 10g <input type="checkbox"/> 15g <input type="checkbox"/> 30g (max)	<input type="checkbox"/> 10g <input type="checkbox"/> 15g <input type="checkbox"/> 30g (max)
HELIX3-CM® Collagen Matrix	Min-Mod	A6021	<input type="checkbox"/> 1" x 1" <input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
HELIX3-CM® Collagen Matrix	Min-Mod	A6021	<input type="checkbox"/> 4" x 4"	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
HELIX3-CM® Collagen Matrix	Min-Mod	A6023	<input type="checkbox"/> 7" x 7"	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
HELIX3-CG Collagen Gel	Min-Mod	A6011	<input type="checkbox"/> 7 gram	<input type="checkbox"/> 5 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 5 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 5 <input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
AMERX® Calcium Alginate Dressing	Mod-Hvy	A6196	<input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
AMERX® Calcium Alginate Dressing	Mod-Hvy	A6197	<input type="checkbox"/> 4.25" x 4.25"	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
AMERX® Bordered Gauze Dressing	Any	A6219	<input type="checkbox"/> 1" x 1" <input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30
AMERX® Bordered Gauze Dressing	Any	A6220	<input type="checkbox"/> 4.25" x 4.25"	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30
AMERX® Foam Dressing	Mod-Hvy	A6209	<input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)
AMERX® Foam Dressing	Mod-Hvy	A6210	<input type="checkbox"/> 4.25" x 4.25"	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)
AMERX® Bordered Foam Dressing	Mod-Hvy	A6212	<input type="checkbox"/> 2" x 2" <input type="checkbox"/> 4" x 4"	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)
Other:						

SECONDARY DRESSINGS TO BE DISPENSED

AMERX® Bordered Gauze Dressing	Any	A6219	<input type="checkbox"/> 1" x 1" <input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30
AMERX® Bordered Gauze Dressing	Any	A6220	<input type="checkbox"/> 4.25" x 4.25"	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30
AMERX® Calcium Alginate Dressing	Mod-Hvy	A6196	<input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
AMERX® Calcium Alginate Dressing	Mod-Hvy	A6197	<input type="checkbox"/> 4.25" x 4.25"	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)	<input type="checkbox"/> 15 <input type="checkbox"/> 30 (max)
AMERX® Foam Dressing	Mod-Hvy	A6209	<input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)
AMERX® Foam Dressing	Mod-Hvy	A6210	<input type="checkbox"/> 4.25" x 4.25"	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)	<input type="checkbox"/> 12 (max)
Other:						

MISCELLANEOUS DRESSINGS TO BE DISPENSED

AMERIGEL® Saline Wound Wash	Any	----	<input type="checkbox"/> 4 oz. <input type="checkbox"/> 7.1 oz.	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
AMERX® Bordered Gauze Dressing	Any	A6220	<input type="checkbox"/> 4.25" x 4.25"	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30
Gauze Sponge	Any	A6216	<input type="checkbox"/> 2" x 2"	<input type="checkbox"/> 30	<input type="checkbox"/> 30	<input type="checkbox"/> 30
Sterile Gauze Sponge	Any	A6402	<input type="checkbox"/> 2" x 2" <input type="checkbox"/> 4" x 4"	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30	<input type="checkbox"/> 15 <input type="checkbox"/> 30
Conforming Bandage (4 yard rolls)	Any	A6446	<input type="checkbox"/> 4.5"	<input type="checkbox"/> 4 rolls <input type="checkbox"/> 8 rolls	<input type="checkbox"/> 4 rolls <input type="checkbox"/> 8 rolls	<input type="checkbox"/> 4 rolls <input type="checkbox"/> 8 rolls
Rolled Gauze Bandage (4.1 yard rolls)	Any	A6446	<input type="checkbox"/> 3" <input type="checkbox"/> 4"	<input type="checkbox"/> 4 rolls <input type="checkbox"/> 8 rolls	<input type="checkbox"/> 4 rolls <input type="checkbox"/> 8 rolls	<input type="checkbox"/> 4 rolls <input type="checkbox"/> 8 rolls
AMERX® Retention Tape (11 yard roll)	Any	A4452	<input type="checkbox"/> 2"	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls
Clear Tape (10 yard roll)	Any	A4452	<input type="checkbox"/> 10 yard roll	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls
Paper Tape (10 yard roll)	Any	A4450	<input type="checkbox"/> 10 yard roll	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls	<input type="checkbox"/> 1 roll <input type="checkbox"/> 2 rolls
Other:						

COMPRESSION GARMENTS TO BE DISPENSED

PRODUCT: COMPRESSION GARMENT	HCPCS	LEG #1 SIZE Note quantity of garments in front of size. See example.*	LEG #2 SIZE Note quantity of garments in front of size. See example.*	COLOR
EXTREMIT-EASE® Venous Stasis	A6545	____XS ____S ____M ____L ____XL ____XXL <input type="checkbox"/> Regular <input type="checkbox"/> Tall	____XS ____S ____M ____L ____XL ____XXL <input type="checkbox"/> Regular <input type="checkbox"/> Tall	<input type="checkbox"/> Black <input type="checkbox"/> Tan
EXTREMIT-EASE® Lymphedema	A6583	____XS ____S ____M ____L ____XL ____XXL <input type="checkbox"/> Regular <input type="checkbox"/> Tall	____XS ____S ____M ____L ____XL ____XXL <input type="checkbox"/> Regular <input type="checkbox"/> Tall	<input type="checkbox"/> Black <input type="checkbox"/> Tan

- List of 30 Standards and Complaint Resolution Form Dispensed to Patient.
- Patient / Family Educated Regarding How to Apply and Use at Home.

*EXAMPLE FIELD FILLED OUT

____XS ____S <u>1</u> M <u>2</u> L ____XL ____XXL
<input checked="" type="checkbox"/> Regular <input type="checkbox"/> Tall

TREATING PRACTITIONER'S SIGNATURE: _____

ONLINE RESOURCES

For the latest information and updates from AMERX Health Care, visit the AMERX Blog and follow AMERX Health Care on social media:



[AMERXHC.com/blog](https://www.amerxhc.com/blog)



[linkedin.com/company/AMERX-Health-Care](https://www.linkedin.com/company/AMERX-Health-Care)



[facebook.com/AmerxHC](https://www.facebook.com/AmerxHC)



[instagram.com/AmerxHC](https://www.instagram.com/AmerxHC)

CUSTOMER SUPPORT

For additional questions regarding coding and billing for AMERX products, log in to your member account on **AMERXHC.com** for the latest updates and resources, or contact your Account Manager at **(800) 448-9599**.

Disclaimer: *The information provided in this packet is intended to educate health care providers regarding Medicare requirements for dispensing DME Wound Care Supplies. The information provided does not guarantee reimbursement and is accurate to the best of our knowledge at the time of this publication. Local Coverage Determinations (LCDs) can change from time to time and we encourage you to stay up to date with your latest LCD provided by Medicare. Most private insurance payers will follow Medicare's LCD, however, others will alter Medicare's LCD to restrict usage or require additional documentation. It is up to each practice to request a copy of the current LCD for DME Wound Care Supplies from contracted private insurance payers and comply with their requirements. Any specific questions regarding billing requirements should be directed toward the payer or www.dmePDAC.com.*

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